Illinois Department of Employment Security
Name of Office
Office Address
City, State, Zip
Phone: (xxx) xxx-xxxx · TTY: (xxx) xxx-xxxx
www.ides.state.il.us

Instructions

(form on page 2)

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Claimant Name
Street Address
City State Zip

Date Mailed: xx/xx/2010
Claimant ID: xxxxxxx

Extended Benefits Work Search Form

(Este es un documento importante. Si usted necesita un intérprete, póngase en contacto con su oficina local.)

To be eligible for State Extended Benefits (EB) you must make a SYSTEMATIC AND SUSTAINED effort to find work and provide a record of this work search to our Department. You must have at **least five employer contacts per week, apply for work on at least three days during each week you are claiming, and make positive efforts daily to find work. If you claim EB for a week during which you do not meet these requirements, you will be ineligible for that week and all future EB payments until you return to work and requalify**. If you do not meet the work search requirements, you should "waive" the applicable week(s) when you call TeleServe. On this form, cross through the week(s) you wish to "waive". By waiving the week(s) in TeleServe, you will prevent payment for the week(s) in which you did not meet the requirements, but will not cause a denial of future weeks. **It is recommended you retain a copy of this form. If you misplace your form, a blank one can be obtained on our website at www.ides.state.il.us. If you are enrolled in either full time or part-time approved training under Trade Adjustment Assistance (TAA) or enrolled in any full time training approved by the IDES, you are not required to submit any work search form.**

Week Ending 1: xx/xx/2010

Week Ending 2: xx/xx/2010

Date to Mail or FAX: xx/xx/**2010**

If you are certifying for benefits for the weeks listed above, indicate your effort to secure work for these weeks below and FAX or MAIL this form on the date indicated above. FAILURE TO COMPLY WILL RESULT IN A DENIAL OF BENEFITS AND A POTENTIAL OVERPAYMENT.

Claimant Name _____ Date: _____ Clear

Extended Benefits Work Search Form

Claimant SSN: _____
Claimant Name: _____
Week One Ending Date: _____
Week Two Ending Date: _____

Please sign and either mail this form to IDES at P O Box 4370; Fairview Heights, IL 62208 or FAX it to (866) 997-0238. If you need additional space, please use the other side of this document, if appropriate or a separate sheet of paper.

Contact Date	Employer Name and Address	Person Contacted, if applicable	Method of Contact	Type of Work	Results/Outcome
Week 1					
Week 2					

Signature

Signature: _____ Date: __/__/____

Name (printed): _____ Daytime Telephone Number: (___) ___-____

Title: _____